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Stacy Gehringer (00:06):

Hello. Welcome everyone. Thank you for tuning into the CASCW Podcast Channel. My name is Stacy Gehringer and I'm the Outreach Director at the Center for Advanced Studies in Child Welfare. We are excited to share our latest podcast series with you. This series is titled Early Development and Child Welfare and features interviews with a variety of professionals in the fields of early childhood and child welfare listeners will enjoy content related to attachment culture, screening, brain development, infant mental health, and more. Please be sure to subscribe to our channel for future episodes. Thank you for listening and take care.

Faith Edson (00:50):

Hello everyone. This is Faith Edson, and I'll be your host today. And I am joined by my colleague, Dr. Sarah Shea. Thank you so much for being here Sarah to talk with us about using the infant mental health lens when working in social work and child welfare.

Dr. Shea (01:10):

Thanks for having me Faith.

Faith Edson (01:12):

Absolutely. I'm really excited for our conversation. So, I figured we could just start, if you don't mind talking a little bit about what do we mean when we say infant mental health? What are the guiding principles? How do you define it?

Dr. Shea (01:29):

Yeah, well, so I think, there's some really great definitions out there about infant mental health. In terms of thinking about it with regard to child development. So when I think about infant mental health, I think about that social and emotional development that happens from birth to three. But it's not, you know, the baby in isolation, right, developing socially and emotionally, it's, it's really about their social and emotional development in the context of their relationships and their culture. And so attachment is like a big, a big piece of that. Um, and the ability to understand one's own feelings and responses and problem solve, which obviously doesn't get all wrapped up by the age of three, but it's those building blocks that are happening during those times. And it's really the experience that they have with the people who are caring for them that help support that development.

Dr. Shea (02:32):

Yeah, so, I mean, that's the way that I think about it. But in terms of those principles, then, you know relationship then is the priority in all aspects of development, because if there isn't that experience of a safe, consistent, predictable and compassionate relationship, the child isn't really able to develop those skills that I just described. They're not skills that you teach, you know, giving a step-by-step nstruction. They really have to be experienced in the relationship for the baby to be able to start to develop those capacities and then grow them over time. So relationship is really central. And when we think about infant mental health, I think we're focused on recognizing that caregivers are doing the very best that they can in terms of parenting and supporting their children with what they have and what they

experienced. And I know its said a lot of different ways, but I think it's important to always keep in mind that it's really difficult to give what you haven't received. So parents are doing the best that they, that they can with what they have. And when you enter a relationship with parents that way, there's a lot, there's a lot more room for empathy rather than judgment or blame.

Faith Edson (04:15):

Absolutely. Thank you. It's, you know, when people hear infant mental health, sometimes they think about mental illness, right. Because in our culture and world, and so your description really reminds us that it's about, it's about health, it's about wellness, mental wellness, and the foundation for that being created in relationships in those first few years of life.

Dr. Shea (04:36):

Yeah,

Faith Edson (04:38):

So I'm wondering if you could maybe talk a little bit about your professional journey into the field of social work and really aligning social work and child welfare with infant mental health and, you know, how you came to be here in this place.

Dr. Shea (04:57):

Sure. So, when I think back on that pathway at the time, it was not very clear, but now of course, it all makes sense that this is why I'm in infant mental health. I always loved working with children that was a passion of mine from a very young age. And, but I was not familiar with social work or certainly infant mental health. And when I graduated from college, I had a really strong commitment to social justice. That was a theme for me. And then I know I knew I loved working with children and I served for a year as an AmeriCorps Vista volunteer working on a, early literacy project in Boston with several daycare centers and headstart programs. So it gave me access to get to spend time with small children and work on, you know, this project.

Dr. Shea (05:57):

and it led to a position as a case manager in a headstart program. And over time there, I you know, was kind of, there's not a lot of training for that. I certainly didn't get a degree in that area of practice. So I was learning on my feet and just exposed to a lot of different experiences of trauma for children and families. Certainly poverty, violence, you know, just learning almost experientially. And during that first year there was a really tragic experience where a child that I was working with died and she died due to child abuse. You know, it was not like that's a common experience in the headstart program. So it feels almost, you know, I think about that a lot like that that happened during my first year, you know, really in a real job outside of college.

Dr. Shea (07:05):

And it really impacted me as I think it would impact most people. You know, there was certainly a lot of secondary trauma around that and thinking about what went wrong, what could have been done, what could have been prevented. And I think that over time that, you know, throughout that year, and the next year, I really felt this commitment. Like I needed to understand how that happened. In some ways there's a naive, you know component to that, because I think I was like, well, I'll just learn more and

figure this out. Like I have to figure it out. And I don't know how many people are familiar with the Enneagram, but I was not at that time, but I am a five and a six. And so it makes a lot of sense that I was like, well, I just need more information to solve this, this, you know, mystery about, for me, why this, why this all happened?

Dr. Shea (08:06):

Because I was very aware that it was not just because a parent had abused their child, that there was like a bigger piece to this. And so I had watched a play therapist in the headstart program and I really wanted to do what she did, and she had an MSW degree. So I applied for my MSW to pursue clinical social work and to be able to do therapy. And in one of my very first classes, they talked about attachment theory. And I remember just thinking, well, this just explains everything. I'm like, this makes the most sense. And, they talked about baby watchers who would do observations of small children, and I'm like, I am a natural baby watcher. Like, that's what I wanna do. But I think I was really wrestling with all of those pieces that had impacted this family, this community that had resulted in this little girl's death.

Dr. Shea (09:07):

And it really stayed with me. And I actually recently revisited, I had written a poem after I graduated with my MSW about the little girl, and it was interesting to me to go back because when I entered MSW school, you know, I was going to get the answers. I was going to figure it out. And when I finished, there were obviously a lot more questions, but I recognized you know, that there were, there was poverty, there was discrimination. There was community violence and there was this intergenerational trauma for this family and for so many families that had resulted in this tragedy and that I knew I needed to stay in this field to find some way to feel like I could make an impact. And I think, you know, I eventually that led me to working in clinics with families and children, and it just became so clear.

Dr. Shea (10:10):

You could not just work with the child, that it was the parent and the child together. And I just found my way to the baby watchers, and started, I mean, I just called it infant mental health was new. And I was in New York at that time. It was not as well developed as it was in Michigan. I just literally like Googled every single person who had something to do with attachment. And I don't even know how many emails I wrote to get connected and beg for like an internship. And then a job in a clinic that was doing early childhood infant mental health, which was not typical. So I feel very fortunate that people took a chance in so many ways. Um, but then once I was doing that, I just, that was it. That was the right place to be.

Faith Edson (11:07):

It's, you know, it's not an uncommon story, right. About how folks come to this work, right. This sense of there's more to the story here. Um, and I feel moved to know and, and, and to, and to be helpful in, I hope it's okay for me to pull out a few more infant mental health principles I heard in your story.

Dr. Shea (11:32):

Yes.

Faith Edson (11:33):

Maybe we can chat about them if you have thoughts, but there were just so many pieces of, you know, how we are in thinking about infant mental health in the work, whether, you know, in child welfare and in all other settings, you know, one of them that came up was your sense of curiosity and being open to learning and open to wondering, and what else, what else is going on here for this child, for this parent, for this family, for this community, right. And not stopping at kind of the paradigm that I think a broader culture gets stuck in, which is there's a good parent and a bad parent and, you know, it's cut and dry. And then we just, if they're bad, we remove. And if they're good and, and that you were already aware as you experienced this pain, that there there's much to wonder about. There's much to be curious about and that every family's story is unique, every child is unique. Um, and we have to approach each story with that stance. So that, that felt really significant to me. You were kind of set up and ready for that. I think the other thing, you know, in order to do this work, to say, I'm going to dig in even deeper, a hopefulness, right. That you brought that, you know, I think in infant mental health, the birth of a new baby, you know, we, we really believe, brings hope.

Faith Edson (12:54):

It brings the chance of a new beginning for the family and for us as service providers, right? What is possible in this relationship, this new budding emerging relationship. So, I mean, you had to have that hope to keep, right. I'm going to do this thing, and I'm going to dig in and I'm going to, I'm going to see where I can make a difference. So not falling into despair, but really finding the hope. And then I think obviously the third one I pulled out there were many, was you know, relationship as our, as our entry in, and also as our most powerful professional tool. That the relationship that we build with families and that the relationship that the baby has with caregivers is where the, is, where the work is. I often say I can be a therapist once or twice a week. Um, but that's not going to make a difference if the baby doesn't get what he or she needs every other minute of every other day. Right. So how do I use my relationship with caregivers in service of this little one getting what they need from their caregivers? So I don't know if that spurred any thinking for you, but I just, those principles came to mind as you were talking.

Dr. Shea (14:04):

Yeah, actually I think when you said that about relationship, I was thinking, yes, the relationship, um, for, you know, that I was watching or learning more about the parent child relationship or the caregiver child relationship and how that was so central and that I needed to work on creating relationships with caregivers. You know, I was already pretty good at creating relationships with little ones that felt natural to me, but really to find spaces for understanding a caregiver and recognizing too that, um, like, you know, in the instance of this, of this child's death, you know, that didn't mean condoning or tolerating what happens there like, and I think that that can be a real difficult thing sometimes for people to understand is that this field doesn't say, or doesn't, you know except that children are treated that way or maltreated that way.

Dr. Shea (15:02):

But if we don't understand it, how can we ever work to make it different? And so I think that was a big piece for me, but I also think about the relationships that I had professionally that got me through, because you cannot do this kind of work in isolation. It's too much to bear. I mean, you know, I'm talking about this decades removed from that loss, but I still, I mean, it's always going to be on my mind. Right. It was so early in my career and there were various mentors after the fact, you know, once I went back to school and then, um, you know, had more, um, intensive supervision, um, over the years who I had to

rely on, who really helped me navigate, um, a lot of the trauma that you get exposed to when you're working with young children and families and particularly young children and families affected by the child welfare system and that I could not have done it without those relationships. It's just, the work is not meant to be done that way. We are not meant to be that way. We're not meant to be in isolation like that.

Faith Edson (16:22):

Yeah. Our capacity to hold the complexity of humans, humanity really is set in our, in the relationships around us that can hold us. Right. We're not going to have space if we're not given space for sure. And that story of that little girl, I hear you saying there was pain, there was anger and you also carried curiosity and compassion, and that's just a lot of emotional experience for one person to hold. Right. And so many professionals are working with countless families with that complexity.

Dr. Shea (16:58):

Yes. Yeah. I think about that. And I think,you know, like I said, that's not like an everyday experience for a case manager in a headstart program. And so it was kind of just, I don't know how that happened. But I remember having a clinical supervisor later who said they felt sad that that had happened so early in my career, because it created a sense of seriousness, you know, likely, especially early on a sense of hyper-vigilance about, you know, young children and families. But I think of all the child welfare professionals who are encountering such trauma and loss in various ways, very early on in their careers and then throughout the course of their careers and, there's no to escape the sense of seriousness and the weight and how that changes you and your approach to the work.

Faith Edson (18:02):

Yeah. I'm wondering if you could talk a little bit about how we can apply that infant mental health frame in child welfare, knowing that right. Knowing that child welfare professionals are consistently faced with these challenges. So what about the infant mental health frames specifically, do you think can be useful? We can start with maybe thinking about the direct practice workers, and then maybe we can also think about supervisors and policy, but in direct practice what have you found to be most helpful for workers to kind of take in and integrate into their work from the infant mental health frame?

Dr. Shea (18:45):

Well, I think that sometimes because like you've said, child welfare professionals, particularly direct practice workers might be exposed or are exposed to such significant trauma and loss, that there, you have to do something with that. And so sometimes the response to that is really, is a trauma response itself. Um, and I do think that what I see a lot is kind of a fight response. Which is frustration, anger, you know, and wanting to figure out like, kind of like, I wanted to figure out the reasons, right? How did this happen and how do I make it stop? Right. And there's a value to the fight response in some ways, right. It gets people out, it it's activating. Um, and then there's, you know another way you can respond to stress or trauma, which is to shut down, right?

Dr. Shea (19:50):

And so sometimes we hear about professionals who say, I'm desensitized. You know, and sometimes it's described as if that's a good thing, like I don't feel, and I always think, but if we've lost that ability to feel like some of these stories you should have, you should have some deep feelings about, because this is not okay that this is happening to a child or a family. But to me that just points to, well, the level of

trauma is so high, that these are the strategies you know, professionals are having to use to get through. But what I think happens is, is that we use those strategies, you know, sometimes to not have the feelings and the feelings are vulnerability and pain. And I often think the feelings are what we know that the child might be experiencing.

Dr. Shea (20:43):

And it's, it feels like too much to bear. Um, it's too painful to think about what the child is feeling, and yet there is this shared parallel experience. And so then we either, you know, get numb and say, I'm desensitized. Or we get, we might get in that fight zone and say, well, I need to blame, you know the birth family, a foster family, or sometimes if it's another person in the system, maybe they're blaming the child welfare professional, but to, you know, we have to, we have to get angry. We have to fight. And I, I think that what ends up happening is that it just kind of keeps furthering this cycle of trauma because you don't really ever work through the feelings. And in infant mental health, we talk about that vulnerability is not a bad thing, and it's not necessarily something to be avoided.

Dr. Shea (21:48):

It's sometimes an indicator it's giving you information about the experience of the other. So in this case, maybe the child, but also maybe the parent and that it's not an either or situation. We're not saying that you know, either you have to accept everything that caregivers do, or you, you know, don't accept everything that caregivers do. It's not, it's not either, or you can understand a caregiver while also saying, but this is not an okay situation. But without understanding, we just keep furthering that cycle of disconnection.

Faith Edson (22:36):

So much of what you're talking about, I'm hearing is around just emotion recognition and regulation, which right. Is a core of infant mental health. We kind of set the pathway early on about how we experience and express and regulate emotion by co-regulating and relationship. And what I hear you saying is, you know, for professionals, we can carry forth that understanding of human development, right? The foundation of which is laid in the first years to how we are as professionals, how we are working with families around emotional regulation, this is kind of off script. I'm wondering, and maybe this will lead into thinking about what would help welfare supervisors need to think about as well and policymakers, but what are some of the tools and strategies that you've experienced and have found to be helpful? You know, if you were talking, we're talking to child welfare professionals, you know, what would you advise for them or encourage them to do for themselves in this work?

Dr. Shea (23:41):

Yeah. I mean, I'm a big proponent of reflective supervision, which is something we use in infant mental health to really support our work. So that's not, you know, I know that that's not a standard practice in child welfare right now. But I think having a space to talk with a trusted colleague, or a supervisor about the experiences is important. And I do think that we have this misconception that if we stop to talk about it and we stopped to experience the vulnerability, we stopped to have the feelings. We're never going to be able to get back up again. But the reality is, is that, you know, many, I think many child welfare professionals are operating, you know, with no fuel and that yes, talking about it doesn't necessarily change the reality all the time. But it can change how you feel inside.

Dr. Shea (24:47):

It can decrease that sense of isolation and sense of alone, and it also changes the way you come back into the space with the family. So I do think that that's really important. I also think trying to and this is really hard, but trying to say to oneself that you can't control the outcome. There's a lot of letting go, you can offer, um, what you're trained to offer, whatever, you know, your role is, what you're trained to offer. And you can in infant mental health, we would say, be authentic, right. Offer a true relationship. And if someone is able to receive it, they will receive it. And if they're not, they're not. But it's not ours to control. And that that's really hard when you're working with young children. And again, I think it's acknowledging that young children can't control things either.

Dr. Shea (25:45):

So there's a shared parallel sense of that powerlessness sometimes. I do think that, you know, this, this idea of making differences or making changes for children, if we recognize that, you know, the child needs to be attached right to someone, to the caregiver, they can't live just out there in space. Um, that it's our, you know, even if your role isn't to do therapy with the family, your role is to get in and you know make service plans to ensure that a child's being safe, the relationship that you offer the parent is, it impacts what the parent can offer the child. And so we think about these things as being distinct, you know, like, um, that they're not related, but just like we were talking about earlier, a baby, you know, can't learn about relationship unless they experience it.

Dr. Shea (26:48):

And a lot of the parents who are impacted by the child welfare system may also not have had the relationship experiences to which they were entitled. And we certainly can't repair all of that. Um, but there is like the potential for change. The hopefulness that you referred to earlier is there. When we offer the parent the kind of relationship experience, we would want the parent to offer the child, it's almost like letting the parent or the family see there is this other way, there's this other possibility. And I see it in you. I see you as being able to offer it. And then a parent can take that right then, or maybe they can't take it right then. But the opportunity has been, has been offered.

Faith Edson (27:42):

Yeah. I'm also thinking about, wonder if you could talk about that relationship based way of being, and applying it in, you know, case planning and decision-making, you know, around being aware of how the child, the very young child experiences relationships, right. So we're holding the parents, we're holding experience, we're thinking about safety and I think child welfare professionals are faced with having to make recommendations, having to consider transitions and permanency. What would you say to them as they're, you know, trying to hold this baby or young child's experience in mind, those tough parts of their roles as well?

Dr. Shea (28:23):

Yeah, so I think that those decisions that child welfare professionals are, or recommendations that they're called on to make are so difficult. And I could imagine that they must or I know in speaking with child welfare professionals, they must wrestle with them quite a bit. I think, you know, obviously safety is a priority in terms of making sure that the child is emotionally and physically safe. But I also think that sometimes when things are on paper, it's harder to think about the meaning, right. And so if you have a little one sitting before you, to really think about what will it be for this child to completely cut off a relationship because with very young children, not seeing a parent is the same as the parent just

disappearing. They don't have that sense that you know, my mom is a way and can't see me right now, mom is gone.

Dr. Shea (29:27):

And, that's really, that's a trauma for that child. And so I think about in my work, you know, when I was doing infant mental health home visiting, or clinic-based infant mental health work, and working with families impacted by child welfare. That sometimes, you know, like a kinship grandparent might ask me, should I be allowing my, you know, my grandchild to have contact with their mom, she's sober right now, but she wasn't last week. And we would talk about that about, you know, that there are ways to continue to have contact that are safe. You know, that don't put the child at risk, but allow the child to have that connection. And that, yes, the child's going to experience pain if the parent relapses and is not available to them. But cutting off the relationship. The opportunity for relationship is kind of a, like a permanent thing that can't be undone and this child may grow up with a parent who's not consistently there.

Dr. Shea (30:36):

And, but this grandparent has been there. And we talk about how important that relationship is. So I think one of the things that's so important in child welfare is that, you know, when we talk about babies and parents, the baby is always on the parent's mind. You know, even when the parent is, you know, doing a podcast that, you know, your child is on your mind somewhere, right. With children in foster care, we need to make sure that that child is on someone's mind. And so as many positive relationships as possible are important. And I think about you know, if the parent is not able to have the child in their care safely at this time, that should not necessarily mean that the parent has no contact with that child, or when a child is reunited with their birth parent and no longer needs to be in out of home placement, maintaining that connection with that foster parent is central.

Dr. Shea (31:36):

We almost, it's almost like we forget everything we know when we're in these, you know, when these decisions are made sometimes, in what reality would it ever be like normal for us to live with someone for a few years and have them, you know, be a central part of our life. And then, you know, just decide someone tells us where you're just never speaking to, or seeing them again, uh, that's not, you know, the way the heart works, it's not, it's not, it's not how things should be. And so I think, I always think like maintaining as many positive relationships as possible, even if they're not perfect and no relationship is. Is really important when those decisions are being made.

Faith Edson (32:27):

Yes. Thank you for saying all that. And I think as you were talking, I was thinking back to when we talked about what comes up for us, right. In working in child welfare and our essentially defense mechanisms are trauma responses to the hard work. And I think how you just described what babies need and what, what is best over time and relationship, it does make the work more complex, right? The system's already complex, you know, the child welfare system, the, the resources that exist or don't exist. And then to have to think in this way to have to be open to different possibilities can feel messier. And if we are not feeling emotionally regulated, supported, um, in our work empowered, competent, right? All of those things, it can be hard to delve into that messiness. I can see why sometimes it feels, I don't want to say easier, but simpler to just say, okay, baby's here, you're done moving on, because there's just so many things, right. Hard things that we're holding. And so then it does really connect back to, and so

maybe we can go on to this next question about what would you want supervisors and, you know, administrators and policymakers to know in this work?

Dr. Shea (33:47):

Well, yeah, I was thinking when you just said that, yeah. Most things are much easier if there's like a right or wrong answer and around relationships, there's very, it's very infrequent that there's a right or wrong answer. And I, you know, I find that for myself that sometimes I would just like someone to just give me, you know, a blueprint, this is what you should do, but that's, it's pretty rare that that comes along. I think that when I think about supervisors and policymakers, I guess, you know, I would, I would think that it would be so important for them also to recognize relationships. And so what I mean by that is the relationships with the direct practice staff, that they are people too they're carrying an incredible amount of responsibility of heavy, heavy family situations, you know, repeated trauma, just a lot.

Dr. Shea (34:50):

It's not just a caseload, it's you know, a group of families. And I think that child welfare professionals entered the field for a reason, right? Like you, you choose, you choose your profession. Um, you don't just, you know, become a child welfare profession for no reason. There's a reason. And in my experience, many child welfare professionals have communicated a strong desire to help children and families. And so I think about that and I would want supervisors and policymakers to recognize the value in that. That these are that their staff are people who came into this work with a strong commitment to children and families. And that, that should be honored, um, that they are not just replaceable, or you know, um, I don't know, widgets. This is, you know, in a system like they are people. And when we think about that, I think, you know, again, there is this shared effort to combat vulnerability.

Dr. Shea (35:55):

So I'm guessing, you know, many of the supervisors and policy makers also need to combat, you know, do something to defend against their vulnerability. But we know in infant mental health, there's a parallel process. And, the parallel process can start at the very top of a system and filter all the way down. And so the ways that policies are created and implemented directly impacts staff and their experience of their work, which directly impacts children and families and communities. I think sometimes, you know, people who are in an administrative position who have to make really tough decisions that are not popular decisions or implement policies that maybe they did not create or have any say in, you know, that that is such a hardrole to be in. And so I think, again, just like the practitioner who maybe doesn't want to experience the vulnerability around that, or open up the flood gates, because then how do we close it up?

Dr. Shea (37:01):

There can be a tendency to just kind of tell people this is what's happening and not leave room for people's responses to it. And I think that that is, you know, I think that's a problem. I think it's a problem in a lot of systems. Right. Um, and I think the problem there is that, um, being open to having conversation about what that new policy or what that new process, what that is like, does not mean that people aren't going to do it. It just allows people to feel heard and to maybe not feel so alone in their experience about it. And I think you can think about the parallel of a parent with a young child. I use this one a lot with my students, but like when you take a two-year-old, you know, to the you know, grocery store or drug store, and there's the candy row, you know, rows of candy and they want it and they're throwing a fit and you said, no, you know, thinking about it from an infant mental health

perspective, the answer isn't to say yes, like have all the candy, but you also don't have to go the route of screaming, no, you don't need candy. Why do you even want it? Because there is a middle ground of saying, I know you really wanted the candy, you can't have it. And that's, that's awful. And that's problem, because maybe that's the worst thing that that's happened. That's happened for that two year old that day. Um, and that, you know, we can empathize, we know what it's like to not get what we want right. As adults, and it doesn't feel good and it wouldn't feel good to have another adult try to distract you and say, oh, look at the plane when you tell them some really bad news. So, I think about that, that parallel a lot in systems, that it would be really beneficial for people in leadership roles to think about giving an opportunity to hear how it, how it makes people feel about a new policy while with the understanding that maybe that policy can not be changed at this time.

Dr. Shea (39:04):

But it doesn't mean that opening that opportunity to talk about the experiences. It doesn't mean that people won't be able to move forward. In fact, it might actually help them to be able to go out and do what they need to do. And I mean, that's true also with the child welfare practitioners on the ground who are working with families that sometimes it's okay to talk with a foster parent about the fact that a child is going to be moved and let them have their experience describing how painful that is for them. Yes. It might not. It very well might not change that decision as a court's decision, but it allows some room for that foster parent to grieve and maybe be able to move into a new place in terms of future relationships with children or with a birth parent, who's having their rights terminated that, you know, it's important to give space, to have that discussion. How painful is that? And not to act like we can't talk about it because it will open the flood gates. Sometimes the flood gates have to open.

Faith Edson (40:11):

Yeah. Yeah. It just, to me is part of that complexity that we all learn in relationships about how to hold boundaries with compassion and empathy. And then, you know, it's so uncomfortable when a two year old says, and I want that candy and they start screaming. And so then if we have discomfort and we, aren't kind of aware of that, we do go to the place of like maybe blaming or shaming or yelling sometimes. I mean, I think we've all been there. Um, and we, we talked about this earlier. It's because we're feeling discomfort. It's uncomfortable for us, that our child is upset. And I think what you're pointing out is this shows up, right. And when we're supervising, when we're working with a parent as an administrator, like some days, I don't have space to hold your discomfort and I can get into a space of rigidness and kind of wanting to get some control. Um, and it's born out of our you know, our capacity for empathy and our pain and discomfort. And we just keep coming back to a core, I think also infant mental health principle around self-awareness being aware of our own kind of values and beliefs and emotional responses and practicing, being aware of that and how they're guiding our behavior.

Dr. Shea (41:29):

Yes. Yeah. When you were saying that those moments where, you know, you don't get it right, right. With kids or, you know, with colleagues or, you know, in any relationship, um, I think the only reason, you know, you didn't get it right. It's because you do have self-awareness right. Cause there's the sense of like, something was off there that didn't feel right. It didn't go the way that I would've hoped it went. And so that, that piece, that self-awareness, that's a skill, that's something that you have to build over time. And it's one of those skills that's not in play, you know, every second of the day, no one is self-aware all the time. Just like, no, one's reflective all the time. We'd never get anything done. Like

sometimes you have to just use the spreadsheet, not reflect on it. Um, and so, but th piece of like, why am I feeling this way when I'm sitting with this family?

Dr. Shea (42:19):

Like, what is going on with me? Or why do I notice that I'm super tired every time we're going to have this family team meeting? Like, what is that telling me? And not judging oneself about it, but just being aware of it, like it's information. I think that for me was one of the most valuable things I learned in infant mental health was like not to judge myself for those feelings or responses, but to use them like, oh, this is so cool. It's like telling me something about what may be happening here. I think though, the other piece that goes with that I, one of my favorite things to talk about in infant mental health is the value of rupture and repair. Like all those times that we get it wrong, there's this opportunity to repair it. And then actually rupture and repair is healthier and better for everyone, than just being perfect.

Dr. Shea (43:20):

Like, no one is perfect, but it, you know, if you were always in sync with someone that would mean that you were a little too hypervigilant, you were watching them and always trying to match up with them. It's, it's not, you know, that's not typical, but that rupture and repair can lead to stronger relationships. So I think about all those times that maybe, you know, a child welfare professional feels like I got really tense with a family. Like I, you know, wasn't super responsive or understanding. There's an opportunity to go back and not like throw yourself on the floor and say I'm the worst ever. And, you know, but really to say something was happening here. And I, you know, I noticed that I dismissed what you were talking about and I really want to hear it and what that could mean to a family.

Dr. Shea (44:08):

I mean that, to hear someone say, I want to work on this with you. And, you know, I talk about that with foster parents in terms of their relationships with the children in their care, how powerful a lesson it is to repair something with a child. It's saying you are worth, fixing this with, and then the child can feel like I can make mistakes too, and relationships don't have to end. And if we think about that across the continuum of child welfare, we could think about supervisors who sometimes, you know, supervisors in child welfare also are way, you know, overburdened too much work for one person. Can't possibly meet the needs of every single, you know, staff person that they oversee and all of the other things they do. So there's going to be times that they don't like, that's just, you know, that's just life, but what would it mean to go back and repair it?

Dr. Shea (45:08):

You know, when you know that, you know, something just really didn't work well. Snd what message would that give to the child welfare staff member? And the same with the administrators and the leadership, like, you know, there's times where they miss the mark, but I mean, that's, that's okay to admit like we're human. And I just think about that a lot, um, that people, again, repair requires vulnerability and self-awareness and a willingness to take a risk. And that all of that is very hard, but the payoff is huge in terms of strengthening relationships and communicating messages about how important the other person is.

Faith Edson (45:56):

Yeah. Thank you. I was going to link this, I think a little bit just to the broader field of social work and see what you think, right. That how social work and child welfare and infant mental health, like our, you

know, how we can align our principles of this way of being right. And I'm thinking about the particular population we often work with in child welfare. And so the NASW will say that the primary mission of the social work profession is to enhance human wellbeing and help meet the basic human needs of all people. And so I'm thinking about what we said about vulnerability, being seen, being heard, how it leads to wellbeing and empowerment. And then the, you know, the second, the next part of that is with particular attention to the needs and empowerment of people who are vulnerable, oppressed and living in poverty. And I just wonder, like, as you're talking about that, right. How this is all linked, right? Like what are the ways in which we support particularly a population that has been disempowered over generations because of systemic racism and poverty, and, you know, those types of things that, that what you're talking about, we're doing it as professionals. So we can offer it in a way that some, perhaps a majority of these families have not experienced in their communities perhaps in just in our culture.

Dr. Shea (47:24):

Yeah. I think I'm hearing you read that from the NASW, which, you know, as social workers, it's something we read frequently, but sometimes it just hits you a different way. Maybe it's also the context of this conversation, but you know, for me I chose social work. I knew I wanted to do clinical work, but obviously there's other, you know, disciplines that do clinical work. And I chose social work because I was really committed to social justice. And that, that there's this you know, in social work we say, you're never just working with the person, there's the person in the context of their environment. But I would say the environment includes relationships, right? The environment includes systems. It includes policies. It includes social constructs, so many different things. So I remember in, you know, early in my social work career, learning about how you would never, as a social worker, just diagnose an individual with, you know, depressive mood disorder.

Dr. Shea (48:16):

You would also think about what is impacting their overall biological, psychological and social wellbeing, right? So they are living in unstable housing. They, uh, you know, have lost their food stamps, but, you know, there's food insecurity, like all of these different factors. Um, and you know, another major factor, um, for many of the families that I worked with was, um, the impacts of systemic racism, as you mentioned. And so we would think about all of that and say, so, yes, there's a depressive disorder and that needs to be addressed, but there's also all of these other factors where we're not really gonna make a lot of, um, changes, just addressing the mood disorder. We have to address the broader picture. And that, to me, just like naturally fit and made sense. And when I think about infant mental health, I mean, essentially we're saying that there, you know, there is no baby just out there in space, there is the baby in the context of their systems, which includes, you know, their caregiving relationships, their family relationships, their culture, but also all of these social forces.

Dr. Shea (49:28):

Um, and I think when we think about child welfare and particularly, you know, the disproportionate representation of, um, BIPOC children and families in the child welfare system, there's a huge social justice issue there that are, we privileging relationships to certain groups in our society and that other children don't get those relationships. When we've really established, you know, attachment theory. Isn't just a theory anymore. There's a lot of research to support it. We've established that babies don't just need to be fed and have their diapers changed. Then that in fact they will not thrive their, you know, their brains will not develop all of these bad things will happen if they do not have relationship. So are we saying that children from BIPOC communities aren't entitled to the same consistent, predictable,

compassionate relationships? I mean, I can't accept that. And so I think that the work around supporting families to get what they need to be able to offer the relationships that I really believe parents want to be able to offer their children.

Dr. Shea (50:47):

I really believe that, um, that that needs to be the focus. And that we've had too many generations of, um, of families who have been, misunderstood, judged and discriminated against. And I think there's an opportunity now. I think that there's, I hope that, you know, it seems like there is more of an intention to re think child welfare and what it means. I think that there's more of a focus on co-parenting. And on supporting relationships with birth parents and on recognizing the value and essential nature of birth families, while not negating the importance and value of foster parents as well. And then I think in terms of which families come into contact with the child welfare system, that's also a separate issue that has to be addressed in terms of the disproportionate targeting which we know it's a, it's not, it's a fact for BIPOC communities.

Faith Edson (52:11):

Right. And when you say BIPOC for those who might not know Black, Indigenous and People of Color communities, and yes, I think there are implications, right. For direct practitioners and how we're experiencing a family as well as for supervisors, as well as for policymakers and administrators about, okay, what do we do with this, right. This impact is there. So how does it inform how we're supporting families who have been systematically disempowered? Um, because I think like you said, parents want to offer this. Um, but they haven't been given the tools, the resources and do not feel empowered. And, you know, we each have a role in that, in how we are interacting with each other. And with the families and little ones we're working with.

Dr. Shea (53:00):

Absolutely.

Faith Edson (53:02):

I'm wondering if we could, in this last little bit, just maybe summarize the key takeaways and strategies. So if we were kind of talking with professionals, working with child welfare, who may be newer to the infant mental health framework, right. And are thinking about how do I, how do I apply this in my work? What are the, what would you kind of highlight? We've talked about so many important pieces today. So the main takeaways that we could offer them as, as we say goodbye for this conversation.

Dr. Shea (53:39):

Yeah. I think looking for relationships wherever they are and not, and trying to hold an open stance about what relationships may look like, they don't, um, no relationship fits a certain sort of standard right. Relationships can take many different forms and look many different ways. So looking for a relationship wherever you can find it, um, to connect the child. Um, and that the way that you are, with respect to your relationships, with all of the different, you know, people and families that you come into contact with really impacts the child, like it all filters down. So to be aware of that and, um, recognizing the toll that this work takes on you and thinking about where you can share your vulnerability in a way that feels trusting to you, that feels okay to you. Um, because if you don't, you know, it just, it cuts off connection. It cuts off your ability to be in relationship with others and relate to be honest with yourself.

Faith Edson (55:01):

Thank you so many important, um, takeaways today. And to know that what I think what you landed on is one babies are paying attention. They are taking in all of their experiences, and we as professionals have an impact on this baby's wellbeing through our relationships and how we show up. So, I'm so inspired by all that you've shared today and kind of, I feel as we're ending like reinvigorated, like how do I get back out there? And I think that's the value of the infant mental health lens of a reflective practice and supervision of self-awareness. As, you know, as we think more deeply, we do feel more empowered as we kind of touch base with our own humanity, we then are able to connect with others. And that is empowering, isn't it?

Dr. Shea (55:56):

Mmm Hmm. Yes. Yeah. Thank you so much Faith. I feel like talking with you also helped me to connect more with you know, the work that is important to me around supporting families wherever they are.

Faith Edson (56:12):

Absolutely. All right. Well, thank you, Sarah. Hopefully we'll get another time to talk soon.

Dr. Shea (56:16):

Yeah, that would. Be great.

New Speaker (56:22):

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